Rate/Attendance Change Certification Form

Provider Name: ______________________________

Vendor # ____________________ **Email:** ____________________

Phone # ____________________ **Fax #** ____________________

Address: ______________________________

____

City: ____________________ **State:** __________ **Zip Code:** __________

Remit to Address: ______________________________

Printed Name of Qualifying Family Member: ______________________________

Branch of Service/Agency: ○ Army ○ U.S. Coast Guard ○ GSA ○ National Park Service ○ U.S. Customs and Border Protection

---

Child Name: ______________________________

Effective Date of Change: ____________________ **Date of Birth (DOB)** ____________________

Type of Care: ○ FT ○ PT **Hourly Cost OR *Respite Care Only (*Army Fee Assistance only)** $ ____________

Weekly Cost $ ____________ **Monthly Cost** $ ____________

Does the Family qualify for or receive any other subsidies or discounts? ○ Yes ○ No

If yes, please provide source: ______________________________

Billing Method: ○ Calendar Month ○ 4/5 Week Month **If 4/5 Week billing, provide day of week billing is based upon**___________

Child Name: ______________________________

Effective Date of Change: ____________________ **Date of Birth (DOB)** ____________________

Type of Care: ○ FT ○ PT **Hourly Cost OR *Respite Care Only (*Army Fee Assistance only)** $ ____________

Weekly Cost $ ____________ **Monthly Cost** $ ____________

Does the Family qualify for or receive any other subsidies or discounts? ○ Yes ○ No

If yes, please provide source: ______________________________

Billing Method: ○ Calendar Month ○ 4/5 Week Month **If 4/5 Week billing, provide day of week billing is based upon**___________

Child Name: ______________________________

Effective Date of Change: ____________________ **Date of Birth (DOB)** ____________________

Type of Care: ○ FT ○ PT **Hourly Cost OR *Respite Care Only (*Army Fee Assistance only)** $ ____________

Weekly Cost $ ____________ **Monthly Cost** $ ____________

Does the Family qualify for or receive any other subsidies or discounts? ○ Yes ○ No

If yes, please provide source: ______________________________

Billing Method: ○ Calendar Month ○ 4/5 Week Month **If 4/5 Week billing, provide day of week billing is based upon**__________

Providers who misrepresent information used to calculate Fee Assistance/Child Care Subsidy Benefit may have their Fee Assistance/Child Care Subsidy terminated and would be removed from the GSA Subsidy Administration Program as a qualifying child care provider.

______________________________ ____________________

Printed Name of Qualifying Child Care Provider completing this form — Phone Number

______________________________ ____________________

Signature of Provider completing this form — Date

GSA - Subsidy Administration Section
1500 E. Bannister Rd., Rm. 1061, KCMO 64131
Tel: (866) 508-0371 I Fax: (816) 823-5499
armychildcare.ratechange@gsa.gov

CC 2009-01